TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
AZALEA ORTHOPEDICS & SPORTS MEDICINE

Respondent Name
LIBERTY MUTUAL INSURANCE CORP

MFDR Tracking Number
M4-17-2178-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
MARCH 16, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: Position Summary was not submitted in dispute packet.

Amount in Dispute: $1,783.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "CPT 15120 is defined a split thickness autograft. Per lay CPT code description: 'The physician takes a slit thickness skin autograft from one area of the body and grafts it to an area needing repair. The physician harvests a slit-thickness skin graft with a dermatome. The epidermis or top layer of skin is taken, along with a small portion of the dermis or bottom layer of the skin. This graft is sutured or stapled onto the recipient area of the face, scalp, eyelids, neck, ears, orbits, mouth, genitalia, hands, feet, and/or multiple digits.' The operative record states the following: '2x2 Integra Bilayer' graft was implanted. The provider states 'Next, the Integra Bilayer matrix when then pie-crusted and then secured into place.' This Integra Bilayer graft is a skin substitute graft* and not a 'split thickness autograft' taken from another part of the body. The provider billed an incorrect CPT code."

Response Submitted by: Liberty Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
December 9, 2016	CPT Code 15120-RT	$1,783.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

- X263, W3, 193-The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure.

Issues

Does the submitted documentation support billing code 15120-RT? Is the requestor entitled to reimbursement?

Findings

According to the explanation of the respondent denied reimbursement for CPT code 15120-RT based upon "The code billed does not meet the level/description of the procedure performed/documented. Consideration will be given with coding that reflects the documented procedure."

28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

- CPT code 15120 is defined as "Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)."

The respondent contends that reimbursement is not due because "CPT 15120 is defined a split thickness autograft. Per lay CPT code description: 'The physician takes a slit thickness skin autograft from one area of the body and grafts it to an area needing repair. The physician harvests a slit-thickness skin graft with a dermatome. The epidermis or top layer of skin is taken, along with a small portion of the dermis or bottom layer of the skin. This graft is sutured or stapled onto the recipient area of the face, scalp, eyelids, neck, ears, orbits, mouth, genitalia, hands, feet, and/or multiple digits.' The operative record states the following: '2x2 Integra Bilayer' graft was implanted. The provider states 'Next, the Integra Bilayer matrix when then pie-crusted and then secured into place.' This Integra Bilayer graft is a skin substitute graft* and not a 'split thickness autograft' taken from another part of the body. The provider billed an incorrect CPT code."

A review of the Operative Report finds the requestor wrote "Next, the Integra Bilayer matrix when then pie-crusted and then secured into place.' The Integra Bilayer maxtrix does not meet definition of "Split-thickness autograft"; therefore, the respondent's denial is supported. As a result, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is not due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	4/4/2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.